Request for Immunization Record

Please Print Clearly

Client's Information

Last:_____ First:_____ Middle:_____

Sex: ☐ Male ☐ Female

Date of Birth: ☐☐/☐☐/☐☐☐☐ Medicaid Number (if applicable): ☐☐☐☐☐☐☐☐☐☐

_____

Name of Last Health Care Provider or Clinic

Mother's Maiden Name (name before marriage)

Last:_____ First:_____

Mother's Date of Birth: ☐☐/☐☐/☐☐☐☐

Applicant Information

Relationship to Client: □ Mother □ Father □ Guardian □ Other_____
(please describe, e.g. grandparent)

_____

Last Name First Name

_____

Street Address Apt#

_____

City State Zip Code

PHONE ☐☐☐-☐☐☐-☐☐☐☐

_____

This is to certify that I am the parent, guardian, custodian, or other such person in parental relationship to the client listed above, or the individual to whom the record relates. I understand that all information submitted to San Antonio Immunization Registry System (SAIRS) will be kept confidential.

_____

Signature of Applicant Date